THE EFFICACY OF SECOND CURETAGE IN THE TREATMENT OF LOW-RISK GESTATIONAL TROPHOBLASTIC NEOPLASIA: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Introduction/Background Patients with low-risk gestational trophoblastic neoplasia (GTN) are almost universally cured with chemotherapy, but second uterine curettage has been explored as an alternative to avoid chemotherapy-related toxicities. We systematically reviewed intervention studies to determine whether second curettage in patients with low-risk GTN affects: 1) the proportion of patients requiring chemotherapy; 2) the number of chemotherapy cycles; and 3) the need for multi-agent chemotherapy.

Methodology A literature search was performed including the Cochrane Central Register of Controlled Trials, MEDLINE, EMBASE, and Web of Science. Two authors screened titles, abstracts, and full texts and abstracted data. Risk of bias was assessed for each outcome. Data were pooled using a random-effects model and assessed for heterogeneity. Quality of evidence was assigned using GRADE.

Results Six studies met inclusion criteria; 2 randomized studies (RCT) and 4 cohort studies with control arm (CS). Mean difference in number of chemotherapy cycles was 2.04 fewer in patients who underwent second curettage (95% CI -5.00 to 0.91) based on two pooled RCTs (N=138). Those who underwent second curettage had RR=0.60 (95% CI 0.31 to 1.18) for requiring chemotherapy based on 4 pooled CS (N=1105), and RR=1.17 (95% CI 0.76 to 1.80) for multi-agent chemotherapy. 3 patients went second curettage had RR=0.60 (95% CI 0.31 to 1.18) for requiring chemotherapy based on 4 pooled CS (N=1105), and RR=1.17 (95% CI 0.76 to 1.80) for multi-agent chemotherapy. 3 patients went second curettage had RR=0.60 (95% CI 0.31 to 1.18) for requiring chemotherapy based on 4 pooled CS (N=1105), and RR=1.17 (95% CI 0.76 to 1.80) for multi-agent chemotherapy. 3 patients went second curettage had RR=0.60 (95% CI 0.31 to 1.18) for requiring chemotherapy based on 4 pooled CS (N=1105), and RR=1.17 (95% CI 0.76 to 1.80) for multi-agent chemotherapy.

Conclusion In patients with low-risk GTN, second curettage may increase the proportion cured without chemotherapy, with a trend toward decreasing the number of chemotherapy cycles required, without increasing the risk of requiring alternative chemotherapy. Prospective randomized trials including measurement of safety and fertility data are warranted as the quality of evidence in this review was low.
Management and Outcomes in High Risk GTN – A Regional Cancer Center Experience

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Introduction/Background GTN is a chemosensitive malignancy with an excellent cure rate. Most women having high risk GTN (HRGTN) are treated with EMACO (etoposide, methotrexate, dactinomycin, cyclophosphamide, and vincristine), however, up to 25% of women with HRGTN have refractory disease & require alternate strategies.

Methodology 74 women with HRGTN treated at our center from 2006 to 2021 were retrospectively analyzed. Patients were initially started on EMACO & those who developed incomplete response or resistance were treated with salvage therapy which included various drug combinations (employing etoposide and platinum agents) and surgery.

Results The mean age of patients was 26.58 ± 6.76 years. Prior pregnancy was molar pregnancy in 33 patients (44.6%), abortion in 32 patients (43.2%), 2 had ectopic pregnancy (2.7%) & 7 had normal delivery (9.4%). Lung metastasis was present in 55 patients (74.32%), 7 had brain metastasis, 4 had vaginal & 3 had liver metastasis. Majority of the patients (66.2%) were in FIGO Stage 3 at the time of diagnosis. All patients received EMACO as the first line chemotherapy, 29 patients (39.2%) developed resistance and received EMA/EP regimen alone in 24 patients and EMA/EP followed by TC in 5 patients. Seventeen patients (23.72%) needed salvage surgery – hysterectomy (12), tumor resection (3) & lung metastatectomy (2) and 7 received brain radiotherapy. Complete response to salvage therapy was seen in 82.5% patients. Majority of patients who received salvage therapy had $\beta$-hCG $>10^6$ mIU/mL (p = 0.023) & had FIGO score $\geq 12$ (0.021). The patients were followed-up till May 2022 - 3 deceased during the course of treatment, 3 patients had recurrence and 7 patients conceived successfully and delivered a live baby.

Conclusion EMACO as first line chemotherapy and platinum/or etoposide-based drug regimens along with surgery as salvage therapy in high risk patients were successful in achieving cure in high-risk GTN patients.

Local Myometrial Resection for Chemoresistant GTN

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Introduction/Background Although gestational trophoblastic neoplasms (GTN) are highly chemosensitive tumors; chemoresistance was reported to occur in 15–25% of cases. As most of patients with GTN are within the reproductive age; Local myometrial resection (LMR) combined with uterine reconstruction might be considered in highly selected patients with non-metastatic GTN who wish to preserve their fertility.

Methodology A retrospective report of four cases who had been performed LMR with uterine reconstruction. The data of four cases were collected from computer and paper files of Gestational Trophoblastic clinic, Department of Obstetrics and Gynecology, Mansoura University. All cases were diagnosed initially as low-risk non metastatic GTN then developed resistance to chemotherapy. After re-assessment and counselling; they had been performed LMR as fertility-preserving surgery. The patients were followed up and serum $B$-hCG was checked weekly after surgery.

Results The mean age of the cases was 24.5 years. Three patients were nullipara and one case was primipara. The median operative time was 57.5 minutes and no blood transfusion was needed in all cases. The postoperative course was smooth. The post-operative histopathology revealed choriocarcinoma in two cases, invasive mole in one, and placental site trophoblastic tumor (PSTT) in one. Serum $B$-hCG reached a non-pregnant level after mean of 3.0 weeks of surgery. The follow up data were uneventful except ‘case 3’ who developed recurrence one month after surgery.

Conclusion Chemoresistant, non-metastatic GTN at young age can be managed with local myometrial resection with uterine reconstruction instead of hysterectomy. A multicenter-prospective study is recommended.